SENT VIA EMAIL OR FAX ON
Jun/29/2012

Applied Assessments LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jun/29/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

L5/S1 laminectomy, fusion, and instrumentation with a one-day hospital length of stay

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Neurosurgery

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
02/22/11 – PSYCHOLOGICAL EVALUATION
04/26/11 – PRIOR REVIEW –MD
10/24/11 – CLINICAL NOTE –MD
FEBRUARY 2012 –CLINICAL NOTE –MD
02/01/12 – MRI LUMBAR SPINE
02/21/12 – PRIOR REVIEW –MD
02/28/12 – PRIOR REVIEW –MD
03/29/12 – RADIOGRAPHS LUMBAR SPINE
APRIL 2012 – CLINICAL NOTE –MD
04/26/12 – PRIOR REVIEW –MD
04/27/12 – UTILIZATION REVIEW DETERMINATION
05/02/12 – UTILIZATOIN REVIEW DETERMINATION

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male with a history of low back pain with radiation to the lower extremities. The claimant was noted to smoke a pack of cigarettes a week. A psychological evaluation performed revealed the claimant was not experiencing significant depression or anxiety. The claimant demonstrated adequate understanding of the recommended procedure. The claimant was considered to be a good candidate for surgical intervention. Clinical note dated states the claimant complained of severe lumbosacral pain with radiation to the lower extremities. Physical exam revealed paralumbar muscular tightness with loss of lumbar lordosis and limited mobility. Straight leg raise was reported to be positive on the left. The claimant ambulated with a left antalgic gait. There was weakness with plantar flexion of the bilateral feet. Sensation was decreased in the bilateral S1 dermatomes. The claimant was recommended for posterior L5-S1 decompression, fusion, and instrumentation. MRI of the lumbar spine performed 02/01/12 revealed mild central bulging at L3-4 with mild encroachment upon the central aspect of the anterior portion of the dura. At L5-S1, there was asymmetric bulging noted centrally and to the left of midline causing mild encroachment upon the central and left anterolateral aspect of the dural sac and left neural foramina.

Radiographs of the lumbar spine performed 03/29/12 revealed no evidence of acute radiographic abnormality or instability. The request for L5-S1 laminectomy with fusion and instrumentation with one day length of stay was denied by utilization review on 04/27/12 due to lack of significant instability or spondylolisthesis. Additionally, the claimant was noted to be a smoker, which is a contraindication for fusion procedures. The request for L5-S1 laminectomy with fusion and instrumentation with one day length of stay was denied by utilization review on 05/02/12 due to lack of evidence of instability, spondylolisthesis, fracture, or frank neurogenic compromise.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Based on the clinical documentation provided for review and current evidence based guidelines for the requested surgery, medical necessity is not established. The MRI studies provided for review did not reveal any significant disc space collapse or disc disease at any level. Radiographs of the lumbar spine did not reveal significant motion segment instability in the lumbar spine. The clinical documentation did not fully discuss the claimant's conservative treatment to date or outcome of conservative treatment. The claimant is also a noted smoker and it is unclear if the claimant has attempted smoking cessation. As the clinical documentation provided for review does not meet guideline recommendations for lumbar decompression or fusion, the medical need for the requested service is not established and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES